U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 18 December 2003

In the Matter of:

DOUGLAS C. COUCH,
Claimant

Case No.: 2003-BLA-5381

v.

IKERD BANDY COMPANY, INC.,
Employer

and

ZURICH AMERICAN INSURANCE GROUP,
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:
John Hunt Morgan, Esq.
Edmond Collett, PSC
Hyden, Kentucky
For the Claimant

Carl Brashear, Esq.
Hoskins Law Offices
Lexington, Kentucky
For the Employer

Before: Alice M. Craft
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 et seq. The Act and implementing regulations, 20 CFR Parts 410, 718, 725 and 727, provide compensation and other benefits to living coal miners who are totally disabled due

to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 CFR § 718.201 (2003). In this case, the Claimant, Douglas C. Couch, alleges that he is totally disabled by pneumoconiosis.

I conducted a hearing on this claim on July 29, 2003, in Hazard, Kentucky. All parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 CFR Part 18. At the hearing, Director's Exhibits ("DX") 1-27 and Employer's Exhibits ("EX") 1, 3 and 4 were admitted into evidence without objection. Transcript ("Tr.") at 7-10. Employer's exhibit 2 was excluded because it exceeded the limitations for the submission of evidence contained in the regulations and the Employer failed to show good cause for its admission. Tr. at 9.

In reaching my decision, I have reviewed and considered the entire record pertaining to the claim before me, including all exhibits admitted into evidence, the testimony at hearing and the arguments of the parties.

PROCEDURAL HISTORY

The Claimant filed his application for benefits on February 14, 2001. DX 1. The claim was denied by the District Director of the Office of Workers' Compensation Programs ("OWCP") on October 7, 2002, on the grounds that although the Claimant had contracted pneumoconiosis, the evidence did not show that he was totally disabled due to his pneumoconiosis. DX 22. The Claimant filed a timely request for a hearing on October 11, 2002, DX 23, and this claim was referred to the Office of Administrative Law Judges for hearing on January 24, 2003, DX 27.

APPLICABLE STANDARDS

This claim was filed after March 31, 1980, and after the effective date of the current regulations. For this reason, the current regulations at 20 CFR Parts 718 and 725 apply. 20 CFR §§ 718.2 and 725.2 (2003). In order to establish entitlement to benefits under Part 718, the Claimant must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis is totally disabling. 20 CFR §§ 718.1, 718.202, 718.203 and 718.204 (2003).

ISSUES

The issues contested by the Employer are:

1. Whether the claim was timely filed.

2. Whether Mr. Couch was a miner.

3. Whether he has pneumoconiosis as defined by the Act and the regulations.

4. Whether his pneumoconiosis arose out of coal mine employment.

5. Whether he is totally disabled.

6. Whether his disability is due to pneumoconiosis.

DX 27; Tr. at 6.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and the Claimant's Testimony

The Claimant, Douglas C. Couch, was deposed by the Employer, DX 12, and testified at the hearing. He was born in 1957, and has a high school education. DX 1; Tr. at 11-12. His wife, Phyllis, whom he married in 1977, is his sole dependent for purposes of possible benefit augmentation. DX 1; DX 6; Tr. at 12.

The Claimant testified that he worked a total of twenty-four years in the nation's coal mines. Neither the Director nor the Employer contested that allegation. Six of those years were spent underground. Tr. at 13. His main underground work was on the belt line, shoveling coal and keeping the belts running. Tr. at 14. The rest of the time he worked in surface mines, running heavy equipment, usually loading coal. He said he was exposed to coal dust on a constant basis on the job his entire 24 years working in mines. Tr. at 15. His last coal mine employment was in the state of Kentucky. DX 2; Tr. at 7. Therefore this claim is governed by the law of the Sixth Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (en banc). I find that Mr. Couch was a miner within the meaning of the Act.

The Claimant smoked cigarettes for a total of five years. During the last three years he smoked two packs per day. He quit smoking twenty to twenty-five years ago. The Claimant receives Social Security disability benefits. Tr. at 16. His treating physician is Dr. Glenn Baker, whom he sees every two months. Tr. at 17. Dr. Baker prescribed an inhaler, Combivent, which he uses three or four days a week, or sometimes not as often. Tr. at 17-18, 23. He said he has shortness of breath, and a productive cough. Tr. at 18. He did not believe he could return to any of his work in the mines, and considers himself totally disabled from any type of employment. Tr. at 19. He left the mines in January 2000 when he was laid off. He has hurt his back several times over the years and was contemplating having back surgery at the time of the hearing. He was taking Percocet and Ultram for back pain. Tr. at 20. He thought his back, legs, arms and breathing were all keeping him from working. He was also being treated for high blood pressure, since he was 22. Tr. at 21. At his deposition he said he has trouble with a work-related leg injury, back problems, bursitis in his elbow, partial loss of sight in one eye, kidney disease, and high blood pressure, as well as lung problems. DX 12 at 17-21, 26-27, 28, 32-34.

Medical Evidence

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The following table summarizes the x-ray findings available in this case. The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b) (2003). All such readings are therefore included in the "negative" column.

Physicians' qualifications appear after their names. Qualifications have been obtained where shown in the record by curriculum vitae or other representations, or if not in the record, by judicial notice of the List of A and B-Readers issued by the National Institute of Occupational Safety and Health (NIOSH). If no qualifications are noted for any of the following physicians, it means that I have been unable to ascertain them either from the record or the NIOSH list. Qualifications of physicians are abbreviated as follows: B= NIOSH certified B-reader; BCR= board-certified in radiology. Readers who are board-certified radiologists and/or B-readers are classified as the most qualified. See *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B-readers need not be radiologists.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
03/24/01	Baker (B) 1/0	Barrett (B, BCR)	
04/18/01	Hussain 1/1[1]	West (B, BCR)	Sargent (B, BCR) Read for quality only Quality good
12/18/01		Dahhan (B)	

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV). The following chart summarizes the results of the pulmonary function studies available in this case. Bronchodilators were not administered in any of the tests

[1] On the x-ray reading form, Dr. Hussain marked both "1/1" and "A" opacities. He did not diagnose complicated pneumoconiosis, however; he identified the A-sized opacity as a granuloma.

given Mr. Couch. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. 20 CFR § 718.203(b)(2)(i) (2003).

Ex. No. Date Physician	Age Height	FEV_1	FVC	FEV_1/ FVC	MVV	Qualify?	Physician Impression
DX 9 03/24/01 Baker	43 70"	3.73	4.64	80%	152	No	Normal studies.
DX 8 04/18/01 Hussain	43 69"[2]	3.76	4.57	82.3%	144	No	Normal.
DX 10 12/18/01 Dahhan	41 69"	3.81	4.52	84%	119	No	Normal measurements.

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (PO_2) and the percentage of carbon dioxide (PCO_2) in the blood. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled. The following chart summarizes the arterial blood gas studies available in this case. A "qualifying" arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 CFR § 718.105(b) (2003).

Exhibit Number	Date	Physician	PCO_2 at rest/ exercise	PO_2 at rest/ exercise	Qualify?	Physician Impression
DX 9	03/24/01	Baker	35	95	No	Normal.
DX 8	04/18/01	Hussain	34.9	93.0	No	Normal.
DX 10	12/18/01	Dahhan	36.1/ 36.1	78.1/ 92.5	No No	Normal values.

[2] The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 114, 116 (4th Cir. 1995). As there is a variance in the recorded height of the miner, I have taken the average height (69.3") in determining whether the studies qualify to show disability under the regulations. None of the tests are qualifying to show disability whether considering the average height, or the heights listed by the persons who administered the testing.

Medical Opinions

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis caused the miner's disability. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 CFR §§ 718.202(a)(4) (2003). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 CFR § 718.202(a)(4) (2003). Where total disability cannot be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. 20 CFR § 718.204(b)(2)(iv) (2003). With certain specified exceptions, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 CFR § 718.204(c)(2) (2003). The record contains the following medical opinions relating to this case.

Dr. Baker

On March 24, 2001, Dr. Glen Baker examined the Claimant at the request of his counsel. DX 9. Dr. Baker is board-certified in internal medicine and pulmonary disease, and a B-reader. He took occupational, social, family and medical histories, and conducted a physical examination, chest x-ray, blood gas studies and pulmonary function testing. Based upon his examination, Dr. Baker concluded that the Claimant was suffering from coal worker's pneumoconiosis, category 1/0, based on an abnormal x-ray and significant history of dust exposure. He also diagnosed bronchitis based on history. Dr. Baker opined that the Claimant's pulmonary impairment was due to his coal dust exposure, noting that he had a history of less than ten pack years and a twenty-four year history of coal dust exposure with x-ray evidence of pneumoconiosis. In his opinion, given the Claimant's impairment, and according to the *Guides to the Evaluation of Permanent Impairment*, Fifth Edition, as a person who has developed pneumoconiosis, he should limit further exposure to the offending agent and therefore, this would imply that the Claimant is 100% occupationally disabled for work in the coal mining industry or any similar dusty occupation.

Counsel for the Employer deposed Dr. Baker on January 17, 2002. EX 4. Dr. Baker testified that the results of the pulmonary function testing he performed on the Claimant were normal, as were the results of the blood gas studies. Dr. Baker explained that his conclusion that the Claimant was disabled and should not return to coal mining was to avoid further dust exposure. With respect to his physical capacity from a pulmonary standpoint, however, Dr. Baker found the Claimant would he able to perform the work.

Dr. I. Hussain

Dr. I. Hussain examined the Claimant on behalf of the Department of Labor on April 18, 2001. DX 8. He took occupational and medical histories, conducted a physical examination, and administered chest x-ray, blood gas and pulmonary function testing. Dr. Hussain concluded that the Claimant suffered from mild pneumoconiosis due to dust exposure and granuloma, left lung. Dr. Hussain found a mild impairment, due 30% to pneumoconiosis. It was his opinion that the Claimant retained the respiratory capacity to perform the work of a coal miner or comparable work in a dust-free environment.

Dr. Dahhan

Dr. A. Dahhan examined the Claimant at the request of the Employer on December 18, 2001. DX 10. He took occupational and medical histories, conducted a physical examination, and administered chest x-ray, blood gas and pulmonary function testing. Dr. Dahhan said there was "no evidence of occupational pneumoconiosis or pulmonary disability secondary to coal dust exposure as demonstrated by the normal clinical examination of the chest, normal spirometry, normal blood gases at rest and after exercise and clear chest x-ray." He said Mr. Couch retained the respiratory capacity to continue his previous coal mining work, or work of comparable physical demands. He concluded that the Claimant suffered from essential hypertension, peptic ulcer disease, low back pain and a history of nephritis.

Timeliness

Under 20 CFR § 725.308(a), a claim of a living miner is timely filed if it is filed "within three years after a medical determination of total disability due to pneumoconiosis" has been communicated to the miner. 20 CFR § 725.308(c) creates a rebuttable presumption that every claim for benefits is timely filed. This statute of limitations does not begin to run until a miner is actually diagnosed by a doctor, regardless of whether the miner believes he has the disease earlier. *Tennessee Consolidated Coal Company v. Kirk*, 264 F.3d 602 (6th Cir. 2001). There is no evidence that Mr. Couch was told he was disabled by pneumoconiosis before Dr. Baker examined him in March 2001. I find his complaint was timely.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.
>
> (1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal

workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 CFR § 718.201 (2003).

20 CFR § 718.202(a) (2003) provides that a finding of the existence of pneumoconiosis may be based on (1) chest x-ray, (2) biopsy or autopsy, (3) application of the presumptions described in Sections 718.304 (irrebuttable presumption of total disability due to pneumoconiosis if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed after January 1, 1982) or 718.306 (applicable only to deceased miners), or (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. There is no evidence that Mr. Couch has had a lung biopsy, and, of course, no autopsy has been performed. None of the presumptions apply, because the evidence does not establish the existence of complicated pneumoconiosis, Mr. Couch filed his claim after January 1, 1982, and he is still living. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must consider the chest x-rays and medical opinions. Absent contrary evidence, evidence relevant to either category may establish the existence of pneumoconiosis. In the face of conflicting evidence, however, I must weigh all of the evidence together in reaching my finding whether the Claimant has established that he has pneumoconiosis. *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 211 (4th Cir. 2000); *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22 (3rd Cir. 1997).

Of the three available x-rays in this case, two have been read by one reviewer each to be positive for pneumoconiosis, while all three have been read as negative by other readers. For cases with conflicting x-ray evidence, the Regulations specifically provide,

Where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays.

20 CFR § 718.202(a)(1) (2003); *Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344 (1985); *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31, 1-37 (1991). Readers who are board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a

certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985). Greater weight may be accorded to x-ray interpretations of dually qualified physicians. *Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128, 1-131 (1984).

The March 24, 2001 chest x-ray was read as negative by Dr. Barrett, a B-reader and board-certified radiologist. Dr. Baker, who is a B-reader, found it to be positive. I find this x-ray to be negative based on the greater qualifications of Dr. Barrett.

Dr. West, a B-reader and board-certified radiologist, read the April 18, 2001 chest x-ray as negative. Dr. Hussain, who holds neither qualification, found it to be positive. I also find this x-ray to be negative based on the greater qualifications of Dr. West.

Dr. Dahhan, a B-reader, found the December 18, 2001 chest x-ray to be negative. No reader has found it to be positive. Therefore, I also find this x-ray to be negative.

Given the negative readings by the more highly qualified physicians, I find that the x-ray evidence fails to establish pneumoconiosis under § 718.202(a)(1).

I must next consider the medical opinions. The Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co.*, 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields,* above. Whether a medical report is sufficiently documented and reasoned is for the judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149, 1-155 (1989) (en banc). An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp.*, 6 B.L.R. 1-1291, 1-1294 (1984).

The qualifications of the physicians are relevant in assessing the respective probative values to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-599 (1984). More weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with the miner's condition than a physician who examines him episodically. *Onderko v. Director, OWCP*, 14 B.L.R. 1-2, 1-6 (1989). However, a judge "is not required to accord greater weight to the opinion of a physician based solely on his status as claimant's treating physician. Rather, this is one factor which may be taken into consideration in . . . weighing . . . the medical evidence . . ." *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-105 (1994). Factors to be considered in weighing evidence from treating physicians include the nature and duration of the relationship, and the frequency and extent of treatment. In appropriate cases, a treating physician's opinion may be give controlling weight, provided that the decision to do so is based on the credibility of the opinion "in light of its reasoning and documentation, other relevant evidence and the record as a whole." 20 CFR § 718.104(d) (2003). In this case,

Mr. Couch identified Dr. Baker as his current treating physician. However, the only report from Dr. Baker in evidence is the report of his initial examination. Hence I cannot give his opinion more weight than any other examining physician.

Drs. Baker and Hussain find pneumoconiosis to be present, relying primarily upon their own positive readings of a chest x-ray. I have found that evidence to be negative however, based upon the negative readings by the more highly qualified physicians of record. On the other hand, Dr. Dahhan, a pulmonary specialist, has concluded that the Claimant does not have pneumoconiosis.

The conflicting medical opinions must be weighed to resolve the contrary conclusions. All of the physicians who provided medical opinions did so based on adequate underlying documentation. All provided at least some rationale in support of their conclusions. Thus I consider all of these medical opinions to represent documented and reasoned medical opinions. After weighing all of the medical opinions of record, I resolve this conflict by according greater probative weight to the opinion of Dr. Dahhan. Dr. Dahhan possesses excellent credentials in the field of pulmonary disease. He had the opportunity to examine the Claimant and his reasoning and explanation in support of his conclusions are better supported by the objective laboratory data of record. Thus, I find Dr. Dahhan's opinion to be in better accord both with the evidence underlying his opinion and the overall weight of the medical evidence of record.

I conclude, therefore, that the Claimant has failed to establish that he has pneumoconiosis as the Act requires for entitlement to benefits.

Causal Relationship Between Pneumoconiosis and Coal Mine Employment

The Act and the regulations provide for a rebuttable presumption that pneumoconiosis arose out of coal mine employment if a miner with pneumoconiosis was employed in the mines for ten or more years. 30 U.S.C. § 921(c)(1); 20 CFR § 718.203(b) (2003). Mr. Couch was employed as a miner for over 24 years, and therefore would be entitled to the presumption were he found to have pneumoconiosis.

Total Disability

Even assuming, arguendo, that the evidence established the existence of pneumoconiosis, the Claimant would still not be entitled to benefits because the evidence fails to establish total disability due to pneumoconiosis.

A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921(c)(3), 20 CFR § 718.304 (2003), or if he has a pulmonary or respiratory impairment to which pneumoconiosis is a substantially contributing cause, and which prevents him from doing his usual coal mine employment and comparable gainful employment, 30 U.S.C. § 902(f), 20 CFR § 718.204(b) and (c) (2003). The Regulations provide five methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion; and (5) lay testimony. 20 CFR § 718.204(b) and (d) (2003). Lay testimony may only be used in establishing total disability in cases involving deceased miners, and in a living miner's claim, a

finding of total disability due to pneumoconiosis cannot be made solely on the miner's statements or testimony. 20 CFR § 718.204(d) (2003); *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-106 (1994). There is no evidence in the record that Mr. Couch suffers from complicated pneumoconiosis or cor pulmonale. Thus I will consider pulmonary function studies, blood gas studies and medical opinions.

With regard to the pulmonary function testing, all studies conducted failed to produce values indicative of total disability. Similarly, all blood gas studies of record failed to produce values indicative of total disability. Accordingly, total disability cannot be established pursuant to 20 C.F.R. § 718.204(b)(2)(i) and (ii) (2003).

Left to be considered are the medical opinions of record. Dr. Hussain found a mild impairment, concluding that the Claimant was able to return to his usual coal mine employment. Dr. Dahhan found no impairment. Only Dr. Baker found disability based on the premise that a miner who develops pneumoconiosis should limit further exposure to coal mine dust. This, in and of itself, however, does not constitute a finding of disability pursuant to the regulations or case law. *See Zimmerman v. Director, OWCP*, 871 F2d 564, 567 (6th Cir. 1989). Furthermore, in his deposition testimony, Dr. Baker conceded that the Claimant had the pulmonary capacity to perform heavy manual labor in a dust-free environment. When these and the other doctors' opinions are considered in conjunction with the results of the objective tests, I conclude that the Claimant has failed to establish total disability from a pulmonary or respiratory impairment.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

Because the Claimant has failed to show that he has pneumoconiosis, or that he is totally disabled by a pulmonary or respiratory impairment, he cannot establish that he is entitled to benefits under the Black Lung Benefits Act.

ATTORNEY FEES

The award of an attorney's fee under the Act is permitted only in cases in which the claimant is found to be entitled to benefits. Section 28 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 928, as incorporated into the Black Lung Benefits Act, 30 U.S.C. § 932. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for services rendered to him in pursuit of this claim.

ORDER

The claim for benefits filed by Douglas C. Couch on February 14, 2001, is hereby DENIED.

A

ALICE M. CRAFT
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 CFR § 725.481 (2003), any party dissatisfied with this decision and order may appeal it to the Benefits Review Board within 30 days from the date of this decision and order, by filing a notice of appeal with the Benefits Review Board at P.O. Box 37601, Washington, DC 20013-7601. A copy of a notice of appeal must also be served on Donald S. Shire, Esq. Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Ave., NW, Washington, D.C. 20210.